

EDITORIAL

Nuclear medicine UK: signs of progress

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At last there are clear signs that a road ahead is being mapped. Recent National Institute of Clinical Excellence guidelines recommend a major development for nuclear medicine in cardiology. The present abysmal UK rate of 1.1 investigations/1 000 000/year compared poorly with the known EU rate of 4/1 000 000/year and the inflated rate of 7/1 000 000/year achieved in the USA. National Institute of Clinical Excellence has now issued formal recommendations which will require a significant investment in technology (some 73 additional gamma cameras and staffing) in order to achieve a comparable rate to the EU. Finally it has been formally recognised that this important area of nuclear medicine practice is in need of major expansion. This is good news but poses major challenges. The acquisition of the required technology is the easy part—more difficult will be the recruitment of trained staff (of all disciplines) to meet the new demands. A new network of provision of these services will need to be considered. It will take time but now we have a clear confirmation of an unmet need.

Some 200 UK breast surgeons would now like to implement the practice of sentinel lymph node (SLN) detection in the operating theatre, in combination with the methylene blue approach. The completed axillary lymphatic mapping against nodal axillar clearance sentinel lymph node to sentinel lymph node trial has unequivocally shown the merits of the sentinel lymph

node approach, with major benefits in morbidity for the patients concerned. A meeting is planned where the relevant stake holders (surgeons, nuclear medicine physicians, physicists and pathologists) will attempt to develop guidelines for surgical training and minimal standards for the histopathological assessment of the sentinel nodes. The North London Cancer Board has set up a first sentinel lymph node training course for physicians and surgeons. One critical component will be the level of training required for surgeons to accurately detect the sentinel lymph node. Nuclear medicine staff will be required to help in this training, scarce gamma camera imaging time will need to be identified (see above) and an audit of achieved competency will need to be agreed, monitored and implemented. And the simple H&E examination of many nodes will be replaced by a much more detailed (at least immunohistochemistry) examination of fewer but more appropriately selected lymph nodes.

The role of nuclear medicine in oncology will be further debated, in respect to the provision of PET/CT facilities and staffing and the UK requirements for protected radionuclide therapy beds. The emergence of radiolabelled antibodies with significant therapeutic efficacy in therapy resistant lymphoma has opened an entire new window for nuclear medicine and its practitioners.